NICE National Institute for Health and Care Excellence

Appendix B: Stakeholder consultation comments table

2019 surveillance of Excess winter deaths and illness and the health risks associated with cold homes (2015)

Consultation dates: 9am, Monday 24 June 2019 to 5pm, Monday 08 July 2019

1. Do you agree with the proposal to not to update the guideline?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
National Energy Action (NEA)	Yes	No comment provided.	Thank you for your response.
British Geriatrics Society	Yes	The reviewed evidence is substantial and the justification for not updating the guidelines appears well presented and credible.	Thank you for your comment and indicating agreement with the surveillance proposal.
Public Health England	Yes	The evidence base on which the National Institute for Health and Care Excellence (NICE) guidelines were last updated has not substantially developed or changed so we do not feel that a full update to the guidelines is appropriate.	Thank you for your comment and indicating agreement with the surveillance proposal.

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		However, it is clear from trends in Excess Winter Deaths as reported by the Office of National Statistics, that health impacts related to cold continue to be a significant, if not a worsening, problem. The EWD five-year average reported for 2015/16 was 34,074 while the winter of 17/8 saw the highest number of EWDs (50,100) since the winter of 1975/76.[i] This can be viewed at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/excesswintermortalityinenglandandwales/2017to2018provisionaland2016to2017final. The success of NG6 in fulfilling the stated aims depends on action being taken across the health and social care system; however, in our engagement with stakeholders, the feedback we have received is that implementation is patchy and there is lack of clarity around roles and responsibilities. Models of delivery of health and social care services are changing[ii]. A significant proportion of frontline staff delivering frontline care, particularly social care, have minimal levels of professional training[iii]. It is unclear from the guidelines who is responsible for the teaching and training of this workforce to ensure that they can identify and take action if they identify a household at high risk. Extra comments PHE suggests the addition of the following to the NG6 webpages: Links to a range of toolkits and guidance, such as the Keep Warm Keep Well leaflet, are available the PHE website	Thank you for highlighting the recent Office of National Statistics report for England and Wales (2017/8). The findings of the report are acknowledged in our surveillance report evidence summary Appendix A, which indicates a rise in EWD. The changing epidemiology is something that we will continue to monitor, we will check at future surveillance reviews if current trends are sustained. In the report we have also acknowledged the challenges of implementing NICE guideline NG6 including the issues that you highlight here. During our consultation we asked stakeholders to submit information on local barriers and facilitators to implementing NICE guideline NG6, and we notified them that we would submit collated responses to NICE system support for implementation team and Public Health England (PHE), to support implementation strategies for this guideline. Regarding the point about who should arrange and provide training, as outlined in recommendations 1, 8, 9 and 10 of NICE guideline NG6, there are links to information about 'who should take action?' for each recommendation. It is also stated in recommendation 1 that Health and Wellbeing Boards should develop a strategy to address the health consequences of cold homes, that should include identifying and meeting the training needs of local practitioners involved in providing the services. This concurs with the comments that we made in the surveillance proposal, that: local commissioners and Health and Wellbeing Boards have a responsibility to publicise and promote the activities in the guideline – the success of the recommendations in the guideline will depend on local support structures. Thank you for identifying various resources and information that relate to protecting against winter deaths. We are also aware that

		The recently developed Citizens Advice Cold Homes toolkit at: https://www.citizensadvice.org.uk/about-us/how-we-provide-advice/advice-partnerships/cold-homes-toolkit/. PHE also suggests that the shared learning section of the website be updated. As activities to implement NG6 need to be taken across the wider health and social care system, it may be helpful to signpost to key legislation and guidelines available in relation to homes, for example local authorities' use of the Healthy Homes Safety Rating System (HHSRS).[iv] It may be useful to include a note on the importance of year-round activities as issues with a cold home environment are best identified and managed ahead of the winter season.	local actors may become overwhelmed by too much information, some of which may be broader than the scope of the guideline. We are interested to identify NICE guideline NG6 implementation and support tools, however, those that you identify are not directly relevant to the recommendations in the guideline and therefore may not support implementation of the guideline. For further information on 'resources to support putting the guideline into practice' see chapter 12 of Developing NICE guidelines: the manual. As you recommend, we have checked the NICE shared learning examples for this guideline, we found that it is up to date. No shared learning examples have been received by NICE since 2017. With respect to the last point about adding information to the recommendations about year-round activities to ameliorate problems ahead of the winter season, recommendation 1 in the guideline already advises to develop a strategy that is 'tailored to make any necessary changes, including preventive measures, all year round – not just in the winter'.
Dorset Council	Yes	The Summary of Evidence from Surveillance document is a very useful document	Thank you for your comment and indicating agreement with the surveillance proposal.
Royal College of Nursing	Yes	The reviewed evidence is substantial and the justification for not updating the guidelines appears well presented and credible.	Thank you for your comment and indicating agreement with the surveillance proposal.

2. Do you have any comments on areas excluded from the scope of the guideline?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
National Energy Action (NEA)	No	No comment provided.	Thank you for your response.
British Geriatrics Society	No	No comment provided,	Thank you for your response.
Public Health England	Yes	The risk to health of high indoor temperatures has not been considered in the guidelines. An estimated 2000 heat-related deaths occur each year[v] The review of these guidelines provides a timely opportunity to consider the feasibility of guidelines on reducing excess summer mortality, particularly as housing is a significant modifier of both risks and the contexts for intervention are similar, as are the population vulnerabilities.	Thank you for your response. The current surveillance review considered the need to update NICE guideline NG6. The scope of the guideline covers interventions delivered during cold weather periods. There are currently no plans to develop a NICE guideline on heatwave planning to reduce excess summer mortality.
Dorset Council	No	No comment provided.	Thank you for your response.
Royal College of Nursing	No	No comment provided.	Thank you for your response.

3. Do you have any comments on equalities issues?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
National Energy Action (NEA)	No	No comment provided.	Thank you for your response.
British Geriatrics Society	No	No comment provided	Thank you for your response.
Public Health England	Yes	NG6 currently lists vulnerable groups but the following could also be highlighted for users: Deaths at any age are more likely to occur in winter; excess winter deaths (EWDs) are not simply among the older groups; for example, in winter 2017/18 males under 65 had the greatest relative increase in EWDs[i]. Deaths due to dementia/Alzheimer's disease are considerably more likely to occur in winter. Office of National Statistics (ONS) figures suggest an increasing trend. Socioeconomic factors: People living in cold homes are highly likely to also suffer from fuel poverty. In particular, families with young children, living in the private rental sector (who may not necessarily be in receipt of benefits nor actively seeking support) have been identified by the Committee on Fuel Poverty[vi] as difficult to identify/'hidden' but still at significant risk of cold homes – with many	Thank you for your response. The Committee that developed the guideline noted that information about vulnerable people may be held by a variety of services involved in some aspect of their lives. But action to address problems is likely to be hindered by the lack of access to this information, or lack of understanding of the options available to address problems. One group that was noted by experts who informed our intelligence gathering, but not identified as vulnerable groups in the guideline, was men under 65 – in part, based on recent ONS data. Men under 65 may be covered in the vulnerable population identified in the guideline as 'people on a low-income', 'people with mental health conditions' or 'people with disabilities'. Please also note that homeless people are outside of the scope for this guideline, and excess winter deaths among men under 65 may account for a proportion of deaths in this age group.

		families choosing to 'heat or eat'. As they are not in contact with social services, this is a group that is likely to be more easily identified through other contacts with other services, for example, primary care.	Given that men under 65 had a large and significant percentage point increase in excess winter mortality in the most recent data for 2017/18, we will check at future surveillance reviews if this trend is sustained, but at present there is no reason to support a change to the recommendations. Regarding vulnerable groups and deaths due to dementia/ or Alzheimer's disease, the guideline already mentions vulnerable groups such as people with mental health conditions and people with disabilities. Regarding people who experience fuel poverty, the guideline also mentions people on a low income. The guideline also mentions households with young children (from new-born to school age). Overall, whilst there have been rises in excess mortality for many groups, women are most affected by excess winter mortality. The list of vulnerable groups in the guideline are provided as examples to guide local practice. The categories are broad an encompassing.
Dorset Council	No	No comment provided	Thank you for your response.
Royal College of Nursing	No	No comment provided	Thank you for your response.

4. Are you aware of any local barriers to implementing NICE guideline excess winter deaths and illness and the health risks associated with cold homes (NICE guideline NG6)? Could you please describe local strategies for implementing the guideline and overcoming barriers.

Stakeholder	Overall response	Comments	NICE response

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National Energy Action (NEA)	Yes	About National Energy Action (NEA) NEA works across England, Wales and Northern Ireland to ensure that everyone in the UK can afford to live in a warm, dry home. To achieve this, we aim to improve access to energy and debt advice, provide training, support energy efficiency policies, deliver local projects, carry out research and co-ordinate other related services which can help change lives. This practical insight plays a crucial part in enhancing the authenticity and insights within NEA's national advocacy. Background to this response The winter of 2017/18 saw tragically high numbers of excess winter deaths (EWD) across England and Wales. For the first time in 40 years, the number of EWDs exceeded 50,000. Although the causes of EWDs vary, a significant contributor to needless and avoidable deaths over winter is vulnerable people (who are often already struggling with existing health conditions) being unable to keep their homes warm. As well as leading to preventable winter deaths, cold homes may lead to and exacerbate physical and mental ill health conditions or prompt unsafe coping strategies in those who are struggling to achieve affordable warmth. Despite this, and according to a progress report by the Committee on Fuel Poverty (CFP) and Department for Energy and Industrial Strategy (BEIS)'s Fuel Poverty Statistics published in June 2018, progress against statutory fuel poverty commitments is flat-lining. Our response to this consultation:	Thank you for your detailed response. Thank you for identifying the 'Under One Roof' report which promotes the NICE guideline NG6. Thank you for summarising the recommendations of the report, which we note. The information you provide identifies many challenges for those working in this area. The case examples you cite provide, on the other hand, offer examples of good and emerging practice. We will share your comments with the NICE system support for implementation team and Public Health England, to support implementation and support strategies for tackling excess winter deaths.

		Much of the information presented here has been fully outlined in the report “Under One Roof”, produced by NEA for Liverpool City Council, funded by the Department for Business, Energy and Industrial Strategy (BEIS): https://www.nea.org.uk/research/under-one-roof/. This research showed that, despite the reduction in overall national resources dedicated to tackling fuel poverty and cold-related ill health, some areas are still securing some funding from local sources and/or are leveraging the limited national funding that is available from the Better Care Fund (BCF) or energy supplier funded schemes. Whilst investment from CCGs and NHS bodies in fuel poverty interventions is not widespread, our research showed that it is possible to showcase local examples of actions to implement the NICE NG6 guidance and that local public health teams, other council departments and, sometimes, CCGs or NHS partners can and will act to directly commission initiatives to tackle fuel poverty and cold-related ill health when funding becomes available to them. However, this patchwork of local schemes has created a postcode lottery and often is dependent on passionate individuals working in various sectors who understand the role that preventative actions can play in addressing ill health from cold homes. Local barriers and strategies for implementing NICE NG6: Closing the funding gap and minimising the risk of ill health from cold homes in future The only national funding mechanism aimed at addressing fuel poverty via energy efficiency in England is the Energy	

		Company Obligation (ECO), which also operates across Great Britain. This follows the end of the Warm Homes Healthy People Fund (WHHP) (funded by the Department of Health (DoH) and Public Health England (PHE)), which closed in 2014, and the Department for Energy and Climate Change (DECC)'s Fuel Poverty and Health Booster Fund, which ended in 2015. It also follows the end of Warm Front in 2012, the Green Deal in 2015 and also the Landlord Energy Saving Allowance in 2015. end Any bespoke support for existing health-focussed fuel poverty projects by central Government has now ceased, leaving a "policy gap" within England. This gap has been recognised by the UK Government and many official commentators, most notably the Committee on Fuel Poverty (CFP), the Committee on Climate Change (CCC) and UK Energy Research Centre (UKERC). Increasingly limited funding across local authorities (including public health) and health and social care puts the ability of some areas to replicate existing good practice actions that look to address cold-related ill health at risk. Research carried out by NEA in 2017 found that funding trends in 2017/18 were much more likely to be static or decreasing in comparison to the previous year(s): • Almost half of the schemes surveyed by NEA in 2017 (47%) reported that their level of funding had remained the same as the previous year • For over a third (37%) it had decreased	

		• For 20% of schemes, the reduction in funding was significant • For a small number (6%), funding had increased to some extent • 7% of schemes surveyed had already had their funding stream discontinued between March and September 2017 • 4% of schemes were due to have their funding discontinued by the end of 2017 • 7% of schemes also expected to have funding stopped later in 2018 • Just four schemes (9%) reported a relatively stable funding situation with three schemes reporting that their funding was secure up until 2019 and one with funding secure until 2020/2021 Therefore, the overall picture is one of mounting funding crisis. One of the most common reasons for unsuccessful local funding applications to establish or maintain health-related fuel poverty initiatives is oversubscription of funding bids, as well as the competitive nature of the funds on offer. Other funding challenges were highlighted by 42% of survey respondents. They included: • The short-term and often stop/start nature of funding available to fuel poverty schemes • The lack of consistent or recurrent provision from central government	

		• The inability to engage with time poor health staff, particularly GPs • Competing health priorities and the requirement of many schemes that match funding must be available Cross sector integration at local level: Overall, NEA found that local public health teams were commissioning services for 23% of health-related fuel poverty schemes. Local authorities were contributing funding for 21%. CCGs had commissioned but were funding 8% of schemes, whilst the NHS was only funding 3% of schemes. The research highlighted how local areas need to show greater consistency in meeting the NICE NG6 guideline and develop a standardised approach to cold-related ill health prevention (including relevant hospital discharge practices). Policy levers at a national level are necessary to drive a focus on health-prevention and integration and enable local actors to make a case for investment. There is potential for CCGs, HWBs and NHS bodies to be collectively engaged to deliver the multiple benefits of fuel poverty and energy efficiency actions cost-effectively by improved joint working. Working across organisational barriers is not easy but the best examples show that it is possible. Local public health teams have directly commissioned initiatives to tackle fuel poverty and cold-related ill health. Changes to funding environments can act to dramatically change the nature of the services that they provide. However, good practice examples highlighted within this report show that commissioning from integrated budgets	

		or using existing resources in innovative ways and in ways that speak to national NHS priorities is possible. Teamed with the potential cost-savings to the NHS and the relief of excess winter pressures, affordable warmth initiatives tie in with new health-sector imperatives to increase sustainability, transform services and deliver meaningful actions on prevention. Local public health practitioners consider that tackling fuel poverty and cold-related ill health is a major aspect of being able to reduce health inequalities. An engaged local public health team can act as broker, coordinator and/or funder of actions that cross multiple sectors. Public health teams can apply data insights to understand local public health priorities and to identify where there are gaps in provision. They can bring local actors together to encourage strategic action and build practical referral mechanisms. Efforts to push action from within public health tended to originate with one or two dedicated public health practitioners. At other times, Directors of Public Health were equally as engaged on the issue. When such multi-level buy-in is achieved, more pathways into engaging CCGs and other health sector partners can be opened up. The likelihood of support for fuel poverty services being integrated into prevention-based action from within the NHS still depends on passionate and well-placed individuals. Investment from CCGs and NHS bodies in fuel poverty interventions is not widespread. But, there are cases where health sector organisations have embraced new imperatives to bring health prevention to the forefront of their strategies and have been able to reinforce their	

		new strategic commitments with financial assistance. Some areas have been passionate and determined in their attempts to use such funding in the most effective manner and commission or support services. This often depends on passionate individuals working within health who understand the role that preventative actions can play in enabling them to meet clinical targets. Creating a local business case for support: Multiple types of evidence have been submitted and collated to secure support and/or investment from health and public health bodies for initiatives that look to tackle cold-related ill health. Evidence centres on identified local priorities and evidence of need within a local population, as well as feedback from ongoing or previous scheme delivery. Importantly, local public health teams or CCGs themselves have often had a significant role to play in the identification and collation of such data in the first place, prior to any funding being granted. When presenting a business case for investment to tackle cold-related ill health, being able to tell stories across multiple narratives that use different strands of evidence work best. This will involve: highlighting local Public Health Framework (PHOF) performance indicators; working to understand what those performance indicators might mean for local residents deemed at risk; looking at the number of hospital and GP admissions for health conditions that can be exacerbated by the cold; correlating PHOF performance indicators and admissions numbers with local data on fuel poverty prevalence, property and demographic data;	

		calculating/estimating potential cost savings for the health sector of delivering energy efficiency interventions; telling the story of what life is like for those who are in fuel poverty or who are suffering from cold-related ill health; and using anecdotal data from existing scheme delivery or evaluations to really put a human face onto a case for support. There is much that can be done with data that is already held by local authorities and some local health bodies – often the issue is being able to engage and identify the individuals who can access, interpret and present that data according to the interests of the various bodies involved. Public health analysts are experts in identifying priority areas of need within their population and should be engaged when building a local case for support. Approaching a CCG to ask about their main priorities and who their most at-risk groups might be can be an effective means of establishing how to develop and present a case for support, and to identify the most appropriate target groups for cross-sector initiatives. The tools available to local public health teams to allow them to identify gaps in provision and the issues they need to be prioritising locally are not intended to benchmark performance but inform local strategies. However, where fuel poverty is not considered a priority locally, this can affect the level and extent and support that public health teams are willing or able to provide (as can the quality of relationships locally and their ability to secure the engagement of key, strategic individuals). Persistence in the face of slow change should continue to ensure the issue of cold-related ill health is	

		acknowledged locally as a priority health prevention issue. Ultimately, it is essential that relationships exist locally between key stakeholders that can facilitate the presentation and dissemination of the evidence to relevant local bodies. Often, however, the unavailability of data from the NHS or Department for Work and Pensions (DWP) can limit significantly the targeting and evaluation activities that programme deliverers can undertake. Unwillingness to support initiatives to tackle cold-related ill health from within the health sector may come from the tensions created by evidence not being tailored or presented to those bodies in ways that speaks to their priorities (and in their language). It may also be a result of those bodies being unwilling (or indeed, unable) at this stage to integrate a greater focus on health prevention into their commissioning decisions and service delivery. Evaluating schemes and measuring outcomes Tools like the Health Impacts of Domestic Energy Efficiency (HIDEEM) model (which is used to calculate the health impacts of energy efficiency interventions) and the BRE's Housing Health Cost Calculator could prove invaluable to fuel poverty scheme providers that are required to provide evidence such as returns on investment or quantified cost savings and clinical outcomes (e.g. metrics like QALY). Schemes have also used and produced free resources that can be consulted for calculating Social Returns on Investment, to work out cost savings and the potential benefits of investing in energy efficiency in their locality. There are calculations that local authorities can do	

		using data that they already hold, such as fuel poverty, excess winter deaths and benefits uptake statistics, and data on property condition and tenure. This does not however address the inconsistent application of evaluation methodologies across the country which mean outcomes cannot be measured at scale. Challenges were often encountered in demonstrating improvements to physical health, or impact on local and national trends (such as excess winter deaths and mortality). Such evidence requirements point to a wider epistemological debate about what constitutes 'good evidence'. Health research has traditionally aligned itself to scientific methods of evaluation, such as clinical randomised control trials to assess impact on clinical and acute outcomes. It could be argued that the move towards prevention and integration in the health sector may require it to shift its position and to consider alternative methods more appropriate to the measurement of social determinants of health. Social determinants are extremely complex, and the nature of interventions designed to address them, such as capital measures or advice-based programmes, do not lend themselves easily to more clinical approaches to evaluation. Creating 'budgetary space' to allow for investment of resources in prevention, coupled with appropriately defined outcomes and associated methods for evaluation that will not jeopardise acute spending in the short-term could be one way of overcoming this. This in turn, could act to increase health sector confidence in and acceptance of evidence on	

		outcomes that cannot be easily demonstrated in clinical terms. A need was identified for a data-set tool which could be widely accessed across the sector and which would include information on: PHOF indicators, observatory statistics, excess winter deaths, energy performance, fuel poverty statistics, and relevant income and benefit receipt data from the DWP. Such a development could produce opportunities for more evaluation to be done at scale, should NHS digital be able to use data from existing interventions to observe impact across multiple localities. Limitations on what is possible in terms of evaluation and access to data is perceived as inefficient by stakeholders who felt that time was often wasted creating evaluation tools that were already available, or could be, but they had no or limited access. This was felt particularly strongly in relation to the evaluation of social return on investment (SROI) and quantifiable savings to health and social care. Whilst many schemes are using the NICE guidance as a model for delivery, there remains a need for standardised evaluation models. Integration or overlaying of complementary data sets, such as that contained within HECA reports, could be beneficial to achieving most appropriate and reflective benchmarking of local areas. It was argued that a measure of performance against an established delivery model in terms of health consequences and clinical best practice, as well as associated areas of housing and energy, would be required. Stakeholders were keen to move beyond the current perceived postcode lottery situation in terms of areas	

		where CCGs have been engaged in prevention and are supporting local action, and those that are not. Schemes that have taken steps to measure and demonstrate outcomes that can speak to the clinical interests of health bodies have encountered difficulties in sharing health data. These barriers were felt to be extremely frustrating at a time when schemes are being required to evidence clinical impact, but unable to access tools that could enable them to do so. Adequate data-sharing mechanisms that allow for the tracking of patient service use and outcomes are required. There is a role here for NHS Digital, and those involved in the agreement of data-sharing arrangements locally, in aligning their regulations with the evidence demands being made by health sector organisations. Stakeholders identified a need for greater data-matching and sharing locally. This would enable appropriate data collection and ability to provide evidence of postintervention impacts and outcomes as required by commissioning bodies. More work needs to be done around aligning person-centred data that is held across different local and national government departments with the property-centred data held by local authorities. To do this, good relationships with information governance staff are required. Sharing data and good practice was seen to be critical. But, for it to be successful, the support of specialist data teams needs to be harnessed. Some data officers are more inclined to see the benefit of such a process and therefore invest resources in it, whilst others will not. The process of relationship building and	

		establishing protocols that can be implemented at other similar organisations are needed but can be time-consuming for organisations already resource-stretched. Concerns were raised by stakeholders that the data needs to be strong enough at a local level in order to have an impact. Small data sets that use linear extrapolation from the national data sets and are then downsized to local population size may not be representative. Whilst other data is more accurate at household level (such as fuel poverty assessment tools and EPC data), they are much more time-consuming and resource intensive to use for purposes of targeting and/or outcomes measurement. Best practice case studies Featured below is a summary of the achievements of NEA's own Warm & Healthy Homes Fund (2015-18) and some key projects with our partners. There are also three non-NEA funded best practice case studies of existing schemes that look to tackle ill health from cold homes via fuel poverty interventions. Warm & Healthy Homes Fund (2015-18) Dudley Home Improvement Service (HIS) Dudley's HIS 'Keep Warm Keep Well' hospital discharge service worked in partnership with Dudley Group of Hospitals' cardiology department and Action Heart cardiac rehabilitation programme. During the discharge procedure, patients were referred to Dudley's Keep Warm Keep Well winter warmth support service. All referred patients were	

		offered a home visit to provide energy efficiency advice, income maximisation and loft top-ups, boiler repairs, heating controls etc. St Helens Council St Helens' Affordable Warmth Team worked with the Council's Integrated Access St Helens (IASH) team to identify, target and engage householders. IASH is the single point of access for all social care referrals for those aged 18+. IASH's Pro-active Care Liaison Officers engaged with community matrons to identify patients with cold-related long-term conditions as well as patients frequently attending A&E. The Affordable Warmth Team trialled different referral approaches including engaging directly with GP surgeries to issue Council branded mailshots. Referrals from IASH received a home energy advice visit and heating measures: boiler replacements/new heating systems. Seasonal Health Intervention Network (SHINE) (Islington) Lead organisation: Islington Council Location: London Geographical coverage: Mostly urban Start and end date: 2010 – 2019 (reviewed annually) Estimated annual target reach: 5,000 residents Proportion with a health condition: 50% Brief overview of Seasonal Health Intervention Network (SHINE)	

		The Seasonal Health Intervention Network (SHINE) is a single-point-of-referral network bringing together more than thirty services to support those in or at risk of fuel poverty. The service offers a range of interventions through a dedicated helpline. This includes initial energy advice, ensuring the client is on the best energy deal, referring the client for energy discounts or heating and insulation grants, negotiating debt repayments or clearance, income maximisation and benefit checks, signing eligible households up to the Warm Home Discount or Priority Service Register and arranging additional support services such as fire safety checks, fall assessment and befriending. In some instances, the service provides home visits during which an 'energy doctor' will install small energy efficiency measures, review energy bills, check heating controls and offer energy behaviour advice. For more information about SHINE visit: https://shine-london.org.uk/. Eligibility for SHINE reflects the definition of vulnerable as stated in the National Institute for Clinical Excellence (NICE)'s guidance on 'Preventing excess winter deaths and illness associated with cold homes'. This includes households with an income below £16,190, those with a disability, those with a long-term health condition(s) exacerbated by the cold and households with an occupant under the age of 15 or over the age of 60. Funding SHINE has received funding from a range of sources. This includes Islington Council's Public Health and Housing	

		Departments, Local Authorities across London, an energy supplier as part of their Warm Home Discount obligation and the Greater London Authority's 'Fuel Poverty Support Fund'. Each of these funding contracts is subject to conditions and targets such as the number of client's supported, the number of home energy visits provided and the number of debt cases. The service also utilises funding provided through the Energy Company Obligation (ECO) and highlights the value ECO Flex (a mechanism under ECO which allows Local Authorities to identify households and install energy saving measures in premises) has added to the SHINE package. Islington Council is the lead ECO Flex authority for London, currently signing declarations on behalf of 25 Local Authorities across London, who do not have a statement of intent. Used alone, ECO Flex allows clients to access replacement boilers, loft and cavity wall insulation. Used alongside other funding streams from Local Authorities and/or the Mayor of London's Warmer Homes Scheme, SHINE can benefit from increased funding and a wider selection of measures. In unlocking funding, SHINE has taken a number of approaches. This includes working with partners on bids for funding, scoping funding streams or tender portals and negotiating with existing funders annually to ensure funding for the service is matched or increased. Generating engagement Health sector engagement: In addition to funding from Islington Council's Public Health department, SHINE has	

		generated engagement from a range of health professionals. This includes General Practitioners, General Practice Nurses, Community Asthma Teams, Dementia Navigators, Community Recovery Teams, Enablement services, British Lung Foundation Breathe Easy Groups and Sickle Cell support groups. All of whom identify and refer patients to the service. In generating and maintaining engagement SHINE works with any health body, organisation and professional interested in the service and disseminates promotional materials to encourage referrals. In addition, training sessions are also delivered by SHINE advisors. These provide an overview of the services available through the SHINE network and support in identifying and referring eligible householders. These sessions are tailored to the organisation or team and not only serve as a promotional activity to encourage suitable referrals but as and an opportunity to develop partnerships. It is also felt that having existing relationships with Public Health, General Practices and Clinical Commissioning Group (CCG) has helped give the service traction within the health sector. However, it is noted that changes in team structures and contacts in health services and bodies has made it difficult for relationships to solidify. In addition, the pressures the health service are currently facing hinders health professionals' engagement with fuel poverty. Non-health sector engagement: Being a comprehensive support network for those in or at risk of fuel poverty, SHINE has generated engagement from a range of	

		organisations who provide affordable warmth interventions and additional support to vulnerable residents. This may include services which provide crisis grants, income maximisation, benefit checks and energy and wider debt support, the London Fire Brigade who carry out fire safety checks, handyperson and repair teams, white goods schemes, cookery classes and befriending services. However, maintaining engagement from these partners has been challenging due to the financial and service demand pressures on public services and third sector organisations. Furthermore, changes in team structures has made it difficult to maintain contacts with potential partners. Information and data sharing The information needed to refer a client to SHINE is minimal, with this limited to the reason a referral is being made, client contact information and communication needs (if relevant). Referrals can be made over the phone, email, post or using an online form. SHINE securely shares monitoring data with funders as per contract requirements. The service also shares information needed to make onward referrals. In cases where a referral is made to an established partner the service uses a bespoke Customer Relationship Management (CRM) tools, whilst for ad hoc referrals made to other services, SHINE only does so with the consent of the client and using the service providers preferred referral route. Healthy Housing Hub (Derby City) Lead organisation: Derby City Council	

		Location: Derby City Geographical coverage: Urban Start and end date: January 2012 – ongoing Estimated annual target reach: 1,800 households Proportion with a health condition: 80% Brief overview of the Healthy Housing Hub The Healthy Housing Hub aims to improve the lives of vulnerable residents who's housing negatively impacts on their health and wellbeing and in doing so, reduce demand on health and social care services. The hub provides an array of support. This ranges from low-cost interventions including energy efficiency advice, signing residents onto the Priority Services Register and Warm Home Discount, ensuring the client is on the best energy deal, income maximisation and benefit checks, to repairing or replacing boilers and gas fires, and installing central heating systems. For more information about the Healthy Housing Hub visit: https://www.derby.gov.uk/housing/improvements-and-repairs/healthy-housing-service/. As part of the Healthy Housing Hub, Derby City Council run the Stay Warm and Healthy project between October and March. This provides messaging to community groups, service providers and residents on cold-related ill health and the support available. The project also runs a number of events, during which residents can receive advice and practical support to stay warm and healthy in their home Whilst the Healthy Housing Hub provides advice and referrals to additional service to all residents, providing	

		prescribed works and Healthy Housing Assistance such as home visits and installing or repairing measures is subject to the client being means-tested and being an owner-occupier. Funding The Healthy Housing Hub is predominately funded by the Better Care Fund, a joint funding programme between the NHS and Local Government to join up health and care services and support people to live independently. This has several metrics that the hub must meet, including reducing non-elective hospital admissions, lowering delayed transfers of care and ensuring those who receive intervention remain in their home for a minimum of 91 days following discharge. Whilst the Better Care Fund provides the service with continuous funding, the Healthy Housing Hub also receives short-term funding from sources including electricity distribution networks. The service also utilises funding provided through the Energy Company Obligation (ECO), however it is cumbersome to work with and challenges are noted in finding contractors who are prepared to work with ECO. As a result of this, the Healthy Housing Hub is unable to take advantage of ECO Flex. In securing funding, the service actively seeks new funding streams and highlights particular success in working in partnership with other services on funding bids. Generating engagement	

		Health sector engagement: The Healthy Housing Hub has generated engagement from a range of health professionals, all of whom refer patients to the service. This includes hospital discharge teams, District and Community Nurses, Public Health, General Practitioners, Ward Nurses, Social Services, Carers, Community Matrons, General Practice Nurses, Mental Health teams, Occupational Therapists, Care Coordinators, Pharmacists and the Ambulance service. Generating engagement from the sector has been challenging. This is largely due to the time pressures; heavy workloads and the competing priorities health professionals have. However, the Healthy Housing Hub has overcome challenges by having a presence within health settings. This includes working with the hospital discharge team and speaking to patients on hospital wards ahead of them being discharged, attending meetings, hosting networking events and providing an outreach service at GP clinics for patients to access immediate support. This has allowed relationships to be established and to solidify. The Healthy Housing Hub also has a secure NHS.net email address which has helped increase the number of referrals from health and care professionals. Non-health sector engagement: The service has generated engagement from non-health sector organisations and agencies, who refer clients to the service and/or provide additional specialist support to residents referred by the Healthy Housing Hub. This includes, third sector organisation, community groups, Children's Centres, the police service, Fire and Rescue service, social enterprises,	

		Derby City Council's Housing and Environmental Health Teams. Whilst the voluntary sector has expressed high levels of engagement with the service, funding cuts have placed services under additional pressures and placed a strain on resource. It is felt that establishing contacts and relationships, combined with the service being stable and having operated for a long period of time, has helped generate and maintain engagement. Information and data sharing Referrals to the Health Housing Hub can be made through an online form, phone or email and can be made by third party services or the resident themselves. The information needed to make a referral includes the client's name, address, contact number, date of birth, tenure type, health conditions and any means-tested benefits. The service also requests the clients NHS number which permits health outcomes as a result of intervention to be assessed. The Healthy Housing Hub does share information with others. However, the referral form has a data protection clause under which the client has to express consent for their information to be shared. Data sharing agreements are also in place with partners and client information is anonymised in cases of evaluation or promotion of the service. Healthy Homes Dorset Lead organisation: Public Health Dorset and Dorset Council	

		Location: Dorset, Bournemouth and Poole Geographical coverage: Urban and rural Start and end date: January 2015 to April 2020 Estimated annual target reach: 1,000 – 4,999 households Proportion with a health condition: 100% Brief overview of Healthy Homes Dorset Healthy Homes Dorset, funded by Public Health Dorset and designed and managed by Dorset Council, aims to reduce preventable winter deaths and illness by improving the homes of people vulnerable to the cold. The service offers a range of assistance to vulnerable households including offering energy advice, repairing or replacing faulty boilers, installing energy efficiency measures and referring clients to complementary local support. For more information about Healthy Homes Dorset visit: https://www.healthyhomesdorset.org.uk/. The service's eligibility criteria follows that which is stated in the National Institute for Clinical Excellence (NICE)'s guidance, 'Preventing excess winter deaths and illness associated with cold homes'. This includes low-income households, pregnant women, households with an occupant over the age of 65 or under the age of 5, those with a disability, mental health condition or a health condition caused or exacerbated by the cold, such as cardiovascular and circulatory conditions. However, residents do not need to prove anything where eligibility criteria apply, this is instead done using self-declarations.	

		This approach is designed to ensure vulnerable householders do not face barriers in accessing support. Funding Healthy Homes Dorset is funded by Public Health Dorset but also utilises additional funding through the Energy Company Obligation (ECO), the Warm Homes Fund and the Dorset Accessible Homes Fund. The service also has a 'fund of last resort', which is a ring-fenced funding source which ensures that measures are installed at no cost to the householder, irrespective of the amount of other funding available. Constant changes to funding are one of the services biggest challenges, particularly in ensuring funding is available to support the service over a longer period. However, the service takes every effort to secure funds. This includes scoping for any potential funding streams and partnerships between Dorset Council and the Managing Agent, Centre for Sustainable Energy, to develop funding bids. Generating engagement Health sector engagement: The service regularly engages with the health sector on many levels including strategic links with the Health and Wellbeing Board and engagement from frontline professionals. This includes General Practitioners, Community and District Nurses, Midwives and social prescribers, who identify and refer vulnerable patients.	

		Engagement has been generated and maintained through using every opportunity to meet with and talk to staff at all levels within the sector, with messages tailored to the audience and their functions. However, it is noted that the high workloads of health and care professionals can make it difficult for some to engage with issues such as fuel poverty, energy efficiency and cold homes. Information and data sharing The information needed to refer a householder to Healthy Homes Dorset is minimal, requiring only the name and contact information of the resident. Referrals, including from the client themselves, can be made in several ways, including by phone, email, online form, post or through the SAIL referral network. The service also utilises information to identify possible vulnerable householders. This includes sending promotional literature for the service to residents applying for 'blue badges' and cross-matching housing and GP surgery data to contact patients likely to benefit from assistance. In cases where information is shared, this is done in line with data sharing agreements with the service having developed bespoke arrangements with referrers such as GP practices. Next steps New BEIS and DHSC-led Working Group on Fuel Poverty and Cold-Related Ill Health In October 2018, BEIS and the Department of Health and Social Care (DHSC) jointly hosted a conference as part of Great Green Britain week. The theme of the conference	

		was “Under One Roof: Preventing cold-related ill health, winter deaths and reducing health inequalities through joint working.” Through a process of co-creation, the event brought health & social care, housing and energy professionals together to develop a series of practical propositions – grounded in real experience - for successfully delivering joint action on cold-related ill health and fuel poverty. The focus was on improving people’s lives and their resilience against the cold whilst narrowing the gap between the experience of the richest and the poorest in society. Following the conference, a Fuel Poverty and Cold-Related Ill Health Working Group has been established. Sitting on the group are representatives from BEIS, DHSC, Public Health England (PHE) and NHS England (NHS), as well as third sector organisations including NEA and Citizens Advice. The group aims to: • Influence relevant policies and strategic frameworks that will encourage and enable joint action on cold homes across sectors • Improve awareness of the links between poor housing and ill health across sectors to encourage and strengthen the development of new or existing affordable warmth support services • Support and enable the development and/or establishment of local Single Point of Contact (SPOC) referral services as outlined in the NICE NG6 guidance on excess winter deaths and the health impacts of living in a cold home	

		• Monitor, provide scrutiny, and challenge local bodies on the setting of public health priorities and commissioning of local services Breaking the cycle: Retaining the value of fuel poverty and cold-related ill health initiatives NEA's Under one Roof report makes a series of detailed local and national recommendations to address cold related ill-health. NEA also cites other key steps which would reduce the devastating impacts cold homes have on their occupant's lives. These wider aims have been developed by the cross-departmental health and housing working group mentioned above. Recommendation 1: Re-establish relevant departmental capital spending later this year (for the financial year 2020) which ensures BEIS, the Department for Health and Social Care and Public Health England (PHE) can help sustain existing preventative health-related fuel poverty initiatives. Within BEIS, this would require the continuation and replication of activities previously undertaken via Warm Homes Healthy People Fund (WHHP) or DECC's previous Health Booster Fund to: • Support the development of the updated Fuel Poverty Strategy and in the short-term help address known gaps in national provision • Close the fuel poverty funding gap • Ensure NICE guidance on tackling cold homes is replicated more consistently in all parts of England • Promote long-term cross organisational working	

		• Support the establishment of joint commissioning agreements with local authority partners and leverage the use of Better Care Fund monies to pilot and deliver integrated and joined up services • Help make use of disability facilities grants to fund energy efficiency measures in the most vulnerable homes or using trial new approaches, for example, using hospital readmission fines to invest in preventative health-related fuel poverty initiatives Recommendation 2: As well as securing the relevant departmental capital noted above, BEIS must maintain and strengthen its support for inclusion of the health perspective in the upcoming updated Fuel Poverty Strategy. Recommendation 3: BEIS should fully monetise the health benefits of meeting fuel poverty commitments and include these within Net Present Value (NPV) calculation. The improved HIDEEM model should also be made available to local practitioners as soon as possible and to publish appropriate user guidance alongside. Recommendation 4: The Department for Health and Social Care and Public Health England (PHE) must also ensure the existing the value of preventative health-related fuel poverty initiatives is fully recognised within the upcoming Green paper on Prevention and the forthcoming Green Paper on Social Care in England. This would secure high-level acknowledgement of cold-related ill health as focus within the health sector.	

		Recommendation 5: Within the full three-year Comprehensive Spending Review (CSR), priority for prevention-based activities within the Better Care Fund or its successor must ensure low-income households with long-term respiratory or circulatory health conditions receive priority assistance for preventative energy home improvements.	
British Geriatrics Society	No	On the whole We feel that all the recommendations could be achievable although identifying people in cold homes is challenging for the group that do not necessarily engage with health and social care services as a norm. This group of people are normally only identified when a crisis in their health occurs. There does not appear nationally to be many areas that offer a single point of contact for cold home problems. However, when people are identified as living in cold homes there are organisations that do help although help also appears to vary nationally.	Thank you for your comments. We will share your comments with the NICE system support for implementation team and Public Health England, to support implementation and support strategies for tackling excess winter deaths.
Public Health England	No comment	There are resources available to support implementation should sufficient leadership be demonstrated to tackle this issue (these are detailed below). However, qualitative feedback from participants at relevant conferences, including PHE workshops on the health impacts of cold, indicates that there remains uncertainty around who is responsible for the delivery of the different recommendations within the guidance, and how to support non-clinical and frontline staff to understand when and how to act.	Thank you for your comments. We will share your comments with the NICE system support for implementation team, to support implementation and support strategies for tackling excess winter deaths. Regarding uncertainty around who is responsible for the delivery of the different recommendations within the guidance, NICE guideline NG6 provides information about 'who should take action?' for each recommendation. However, we recognise that local support structures will vary considerably. It is therefore the responsibility of

			local commissioners and Health and Wellbeing Boards to develop strategies to address the health consequences of cold homes, that should include identifying local practitioners involved in providing the services. These responsibilities are clarified and reflected throughout the guideline recommendations.
Dorset Council	No comment		
Royal College of Nursing	No	Overall, it considered that that all the recommendations could be achievable although identifying people in cold homes is challenging for the group that do not engage with health and social care services as a norm. This group of people are normally only identified when a crisis in their health occurs. In Dorset for example, our reviewer has commented that they cannot find any services that offer a single point of contact for cold home problems. We are aware that this is the situation in most areas in the country. However, we know that when people are identified as living in cold homes there are organisations that can help. An example of this is the third sector organisation, *Help and Care* that provides advocacy to support older people who may not be able to solve the problem of their home being cold without help. A national approach to dealing with this issue is vital.	Thank you for your comments. We will share your comments with NICE system support for implementation team and Public Health England, to support implementation and support strategies for tackling excess winter deaths.

[i] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/excesswintermortalityinenglandandwales/2017to2018provisionaland2016to2017final

[ii] https://www.kingsfund.org.uk/publications/health-care-workforce-england

[iii] https://www.kingsfund.org.uk/projects/time-think-differently/trends-workforce-overview

[iv] https://www.gov.uk/government/publications/housing-health-and-safety-rating-system-guidance-for-landlords-and-property-related-professionals

[v] Hajat S, Vardoulakis S, Heaviside C, et al Climate change effects on human health: projections of temperature-related mortality for the UK during the 2020s, 2050s and 2080s J Epidemiol Community Health Published Online First: 03 February 2014. doi: 10.1136/jech-2013-202449

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[vi] https://www.gov.uk/government/publications/committee-on-fuel-poverty-annual-report-2018